

### Discussion.

Dr. Geo. E. Ebricht: We have had considerable experience at the City and County Hospital with patients insisting upon having 606 and sometimes they are very loath to leave without getting the remedy. In such cases, in the absence of leucic history, manifestations or specific reaction, there is certainly no justification in using salvarsan.

Dr. H. D'Arcy Power: I would like to ask what the general experience has been in the matter of weight. In a number of cases that I have seen, some in my own, and many in the practice of others, one of the most marked features was the increase in weight; seemingly salvarsan affects the nutrition as well as the nervous system. It seems to me well worth while looking into the questions as to how rapidly and to what extent the salvarsan affects the weight, together with its general effect on metabolism and the distribution of the metabolites.

Dr. Douglass W. Montgomery: Salvarsan has a strong tonic action and it undoubtedly causes a gain in weight, which, I think, must be due to its stimulating effect on the nervous system and the epithelial cells. About 20 years ago Jonathan Hutchinson instituted an investigation in London in regard to the giving of arsenic by the medical profession; I have forgotten what proportion of the prescriptions contained arsenic, but it was enormous, and rightly so, because it is a tonic which rarely disagrees when given in small doses.

### Section on Surgery of the San Francisco County Medical Society, Oct. 17, 1911.

Case presented by HARRINGTON B. GRAHAM, M. D.

This patient, Frank Roth, has for three years had epilepsy. The last attack was September 23, since when there has been headache, increased lacrymation, sensitiveness to sunlight, pain in the eyes and decreasing vision. On September 27th the hearing in the right ear was diminished, there was slight nystagmus on looking to the right, the nose was full of pus and there was a marked hypertrophy of the lower and middle turbinates on the right side. On October 5th I removed the hypertrophies on the lower turbinate and made a puncture of the right antrum which proved negative. At this time there was marked bilated choked discs with retinal hemorrhages. I lost sight of the patient for a week and then found him in bed with an intense headache, choked disc increasing, and a possible diagnosis being made of intra-cranial affection. My diagnosis based on what I had previously seen in the nose was an accessory sinus affection possibly sphenoidal. The following morning the patient expectorated a large quantity of pus and was entirely relieved of headache. In a few days the disc showed improvement. At present, October 17th, the patient is entirely well except for a slight haziness of the discs.

Ocular affections accompanying accessory sinus diseases are not infrequent and Onodi has recently given an interesting list of them, including thrombophlebitis of the ophthalmic plexus, diplopia, bulbar and peri-bulbar neuralgia, retro-bulbar pain, color scotoma, enlargement of the blind spot for colors, shrinking of the field of vision, retro-bulbar neuritis, choked disc, amblyopia, amaurosis, thrombus of the central artery of the retina, optic atrophy, neuro-retinitis and bitemporal haemianopsia.

Birsch-Hirschfeld calls attention to the fact that a central scotoma may be a very important early diagnostic symptom of tumors and empyemia of the posterior sinuses, especially a unilateral appearance of the same, a rapid development, and the passing of a relative into an absolute scotoma which is combined with a peripheral shrinking of the field of vision. Hoewe claims that before this comes on there is an enlargement of the blind spot for colors.

It is well known that in cases showing neuritis there may be no proportion to the ophthalmoscopic findings. There may be a high degree of blindness

and small ophthalmoscopic findings or vice versa.

The importance of recognizing the sinus affections as the cause of choked disc and other intra-ocular affections is readily appreciated as illustrated in this very interesting case.

### Nephrectomy in a Case of Bilateral Pyonephrosis Recovery.\*

By M. KROTOSZYNER, M. D., San Francisco.

Past history: The patient, a man of 54, was referred to me, about two years ago, by Dr. Wanzer. His family and previous histories are unimportant except that he had lived in a malarial country and had suffered from repeated attacks of intermittent fever during the last 20 years. The first symptoms of his present ailment occurred in the spring of 1906, when he, during the great San Francisco fire, was compelled to camp out for several nights and owing to the exposure and excitement was seized by one of his usual attacks of chills and fever, which, in this instance was complicated by frequent and painful micturition and urinary incontinence. His condition was diagnosed as "inflammation of the bladder" and treated as such for a long time with bladder-washes and internal remedies with the result, that his urinary symptoms gradually increased in intensity, while his general health broke down completely. Of late the attacks of chills and fever occurred almost daily, so that the patient became bed-ridden, prevalent urine dribbled almost constantly from the meatus, he became very emaciated and extremely weak, he was at times semi-conscious and often, especially at nights, delirious.

Present history: The patient looks markedly cachectic and anaemic, his pupils react but sluggishly, he is drowsy and answers incoherently, or not at all, to questions; his skin is dry; his temperature ranges between subnormal and 102° F., his respiration between 20 and 30, his pulse between 100 and 120; it is feeble and at times irregular. By physical examination nothing of pathological note can be revealed except that the lower edge of the liver is palpable about 3 cm. below the costal arch. Kidneys not palpable. Purulent urine dribbles from the meatus into a urinal which lies constantly between the patient's thighs. By catheterization about 400 cc. of urine are withdrawn; upon examination it is found to contain a heavy cloud of albumin, no sugar, no diazo. Indican markedly increased; microscopically: abundant pus, and a few red blood cells; no tub. bac. are found. Noteworthy items of the complete blood examination are: 15,400 Leukocytes, 88% Polymorphonuclears, no Plasmodia; X-Ray plates negative as regards calculi shadows in the urinary tract.

Cystoscopic findings: The first attempts at cystoscopy failed on account of impossibility to obtain a clear medium and because the patient's precarious condition made extended cystoscopic sittings prohibitive. Therefore, the bladder is drained by a retaining catheter, through which the viscus is irrigated twice daily at the bedside, until after innumerable washings a fairly clear bladder fluid is obtained, which though at the next washing is clouding up again. By means of a large-calibered evacuating cystoscope, through the shaft of which the bladder fluid is rapidly exchanged, a brief cystoscopic inspection of the bladder is now feasible (6 days after the patient's entrance into the hospital), which demonstrates a heavily trabeculated and ulcerated bladder-wall, on which the characteristic landmarks of the trigone cannot be differentiated, and a deep and sacculated fundus. An attempt at chromo-cystoscopy fails on account of the rapidity with which the bladder-medium is clouding up. Finally, after many unsuccessful attempts, the left ureter is entered by chance and the right ureteral opening is found in a similar manner by locating

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